Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

FONDRON ORTHOPEDIC GROUP
DAVID W. WIMBERLY
7401 S. MAIN STREET
HOUSTON TX 77030

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number:

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "63035 not paid. But L5-S1 is Accepted as being compenable but has not been paid."

Amount in Dispute: $468.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided surgical treatment to the claimant on 10/13/2010. Texas Mutual denied payment indicating the treatment was unrelated. The requestor requested a BRC and has not filed for medical fee dispute resolution under Rule 133.307. Rule 133.307 at (a)(1) states the provisions of this rule apply to non-network care. The requestor is participating provide in the Texas Star Network and Texas Mutual's claim 99K0000571414 is in the same network. Therefore, DWC MDR does not have jurisdiction to proceed with an administrative review of the requestor's request for medical fee dispute resolution. Instead, the requestor should follow the complaint process with Coventry Workers; Comp Services, which process the requestor was informed of upon admission to the network."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2010	CPT Code 63035 – 2 Units	$468.51	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Tex. Admin. Code §§133.305 and 133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance, Division of Workers' Compensation (Division), Medical Fee Dispute Resolution section on December 19, 2011 for resolution pursuant to 28 Tex. Admin. Code §133.307. In accordance with 28 Tex. Admin. Code §133.307(c)(B)(1) this dispute was timely filed as the extent of injury was resolved through a DWC-24 agreement.

2. 28 Tex. Admin. Code §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care ***not*** [emphasis added] delivered, or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Tex. Admin. Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Tex. Admin. Code §133.305, and §133.307, the Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 4, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.